

CLINICAL LECTURE.

Delivered to the Post-Graduate Class at the Throat Dispensary of the University of Pennsylvania.

BY CARL SEILER, M.D.

GENTLEMEN—The first patient whom I bring before you to-day you recognize as the young man, Frank F., who was here a few weeks ago, and in whose nose I showed you the application of the galvano-cautery to the hypertrophied mucous membrane. You will remember, when you saw him, he was unable to breathe through his nose, on account of the anterior hypertrophies in the left nostril and a deviation of the cartilaginous septum in the right. Since then, as you see, the left nostril has been cleared of obstruction by the repeated application of the galvano-cautery knife, and several days ago I performed on him the operation for the straightening of the septum. I will now remove the pledgets of cotton with which the right nostril was filled after cutting the cartilage and crowding it over into its proper position, and on examining him you will see that there is a very great improvement in his condition, for he is able to blow out the accumulated mucus quite freely out of this nostril. The septum is not yet quite straight, but I have no doubt that in a week or two we will find it so, for the cicatricial tissue formed in the cuts made into the perichondrium, is not old enough to have fully contracted.

The operation was performed in the following manner: After having placed the patient upon the operating table and having brought him under the influence of ether, the head was drawn over the edge of the table and allowed to hang down. This position of the head is preferable to any other in operations within the cavity of the mouth or nose, for it not only facilitates the access to these cavities, but also lessens the danger of blood running into the larynx and trachea, which might choke the patient to death before it could be removed. Standing behind the patient I then introduced the blades of this forceps, one into each nostril. You see that one of the blades has on its face seven knife blades inserted at right angles to its surface and forming a star. This blade I introduced into the open nostril, while the other one was introduced into the obstructed nostril. I then forcibly closed the instrument, thus making a

stellate incision through the whole thickness of the cartilaginous septum. I next introduced a similar pair of forceps, but without the knife blades, and forced the septum into its normal position. This I was enabled to do by the fact that in straightening the septum, the triangular pieces of the cartilage produced by the stellate incision lapped over each other with their apices, thus diminishing the length of the septum and allowing it to assume its normal position. The cartilage itself will not unite in the healing process, but the edges of the perichondrium will form cicatricial tissue and thus retain the septum in a straight line when this tissue has fully formed. Meanwhile we must keep the nostril in which the bulge was seen filled with either wooden plugs or cotton pledgets, as was done in this case, to force the septum over to the other side and keep it in its new position until the healing process is complete. The amount of hemorrhage following the incision was but very slight, and the patient reacted readily from the influence of the ether, and it will be but a few days before we can discharge him as cured.

The next case is one of peculiar interest on account of its rarity, for I do not remember having ever seen one similar to it or read of one like it. This man, W. H., aged 45, an inmate of the hospital, as you see, from his blanched skin and colorless lips, is almost bloodless from repeated copious hemorrhages from the nasal mucous membrane. He tells us that he has had nose bleeding on an average once a month ever since he can remember, and that of late the attacks have increased in frequency and severity, so that within the last few days he has bled three and four times in the twenty-four hours. He feels weak from the loss of blood, but is otherwise healthy. He states that he has two brothers who periodically bleed from the lips, tongue and gums, but do not lose near as much blood as he has done. Neither our patient nor his brothers are afflicted with the hemorrhagic diathesis, for he tells us that wounds of the skin do not bleed inordinately and that the flow of blood is readily stopped.

If you will examine the patient's nose carefully, through the anterior nares, taking care not to scratch the mucous membrane with the edge of the speculum, you will see the mucous membrane

studded all over with small spots of ecchymosis, about the size of a large pin's head. These spots occur both on the septum and on the mucous membrane of the turbinated bones as far as can be seen from in front; they are not noticed in the vault of the pharynx, nor, in fact, anywhere else in the nose. One or two larger ones are situated under the tip of the tongue and on the inner surface of the lower lip, but these, the patient tells us, never bleed. The slightest touch with a blunt-pointed probe will start those in the nasal cavity to bleeding, and the flow of blood can only be stopped by plugging the cavity with cotton saturated with Monsel's solution.

The treatment under which he has been placed, and which has so far materially decreased the number of hemorrhages as well as their severity, consists of a liberal meat diet and full doses of iron. Locally a spray of Monsel's solution, diluted one half with water, is thrown into the nasal cavities several times a day, and every other day the ecchymosed spots are lightly touched with a sixty-grain solution of nitrate of silver. This is done by attaching a piece of absorbent cotton to the end of a silver probe, saturating it with the silver solution and carrying it to the spots to be touched, exerting, however, no pressure upon them with the end of the probe, for fear of starting a hemorrhage. This treatment will be persisted in for some time, until I feel satisfied of either its success or failure; in the latter case I shall try some other application to the spots of ecchymosis.

The next patient is an old colored woman aged 60, whose history is as follows: About a year ago she took a severe cold which settled on her chest, and by which she was confined to bed for several days, probably an attack of acute lobular pneumonia. She got better, but the cough has never left her and gradually she has lost her voice. Within the last few months her throat has become very sore, especially in the act of deglutition, and she has been subject to fits of suffocation, generally at night. Her general health is very bad; she has lost a great deal of flesh and is very weak; sleeps badly on account of the cough and night sweats, and on account of the difficulty of deglutition she cannot take the necessary amount of nourishment.

An examination of her chest which has been

made reveals extensive disease in both lungs. The laryngeal mirror, which she does not bear very well, for the slightest irritation of the pharynx with the edge of the mirror brings on a fit of coughing with spasm of the glottis, shows extreme paleness of the laryngeal mucous membrane, extensive ulceration of the left ventricular band, which is so swollen as to almost meet its fellow opposite. The left arytenoid cartilage is also involved in the ulcerative process and appears fixed in the position of adduction, that is, with the vocal process pointing toward the median line. The vocal cord on that side cannot be seen, as it is covered by the tumefied ventricular band. The right side of the larynx shows no structural changes except that in the act of vocalization the arytenoid cartilage moves slightly past the left one, which, as I have said, is fixed. Now, what shall we do for this woman, to relieve the urgent symptoms of dyspnœa and dysphagia? We cannot attempt to go into the larynx with a brush or sponge to make applications to the ulcerations which give rise to these symptoms, for fear of exciting fatal spasm of the glottis, nor is it even advisable to introduce a spray, which is the mildest form of all local applications. The only thing to be done here, short of letting the patient hasten to a speedy and painful end, is to perform tracheotomy at once, so as to relieve the dyspnœa and give us a chance to make local applications to the laryngeal ulcers with a view to healing them, and making the patient comfortable. Tracheotomy has been recommended in cases of laryngeal phthisis by eminent writers, as a curative measure, even where the extreme necessity does not exist, as in this case, and it is claimed that the complete rest of the larynx and the absence of the irritating influence of the air as it passes over the ulcerated surfaces in the act of respiration, have proved very beneficial in many cases. I have no personal experience in this, for in those cases under my care in which I might have resorted to this rather extreme measure, I could not obtain the consent of either the patient or his friends to perform the operation, as the result of which I could promise only temporary good. In the case before us, however, it is absolutely necessary to open the trachea, for she is in imminent danger of death by asphyxia, and the next spasm may be

her last. We will, therefore, try to obtain a bed for her in the house, and perform the operation as soon as possible.

Here is a little girl, five years of age, who, her mother tells us, suffers from periodical attacks of tonsillitis. In the intervals between the attacks, which occur every two or three months, both in summer and in winter, she snores at night, has difficulty of breathing and talks with a thick voice so as to be almost unintelligible. This, gentlemen, is a case of hypertrophy of the tonsils, a very common affection in children. If you depress the tongue and inspect the fauces, you will see the enormously enlarged glands which almost meet in the median line. They are not inflamed at the present time but are deeply pitted from the enlargement of the mouths of the follicles.

There is but one successful plan of treatment for such a condition as this, and that is ablation of the glands with a tonsillotome. Painting with astringent solutions, burning with caustics, such as nitrate of silver, iodine, chromic acid, etc., or with the galvano-cautery knife, and even the injection of iodine solution into the substance of the gland, have all been tried, and in my experience failed, except in a few isolated cases, to reduce the hypertrophied tonsils; and the removal of the glands is, in my opinion, not only the safest, quickest and surest, but also the least painful of all methods of treatment.

Mathieu's guillotine tonsillotome, the instrument which I will use in this case, is a modification of the old Fahnestock tonsillotome, and I prefer it to other instruments of the kind, because the necessary movements of pushing the stylus or fork forward so as to transfix the tonsil and fix it, and the motion of pulling the annular knife through the gland in cutting it off, can be performed by one hand in rapid succession, thus leaving the other free to depress the tongue and perform other needful services, especially so when the subject is a struggling child.

I will now proceed to remove the tonsils from our little patient here, and you will see that the operation is a very simple one, attended with but little pain and hemorrhage, if done at the right time, namely, when the glands are quiescent and not in a state of inflammation.

OTORRHŒA.*

Gentlemen of the Medical Club:—A few days ago I received a note from the gentleman whose turn it is to read a paper to-night, in which he asked me to supply his place, as he could not be here. I consented, and have done what I could in the very brief time which I have had to spare. I have had no time to read upon the subject, and can give you only a few practical points which experience has taught me.

In this familiar paper I shall not attempt to be logical, consistent or exhaustive, but shall consider the various topics in the order in which they happen to occur to me, using the English nomenclature by preference, but introducing the Latin whenever it will conduce to brevity, or euphony.

Otorrhœa means a running from the ear. It is a broad term and includes every appearance of fluid at the external auditory meatus. We will exclude, however, traumatic hemorrhages, as not coming within the category of true otorrhœas. The ordinary otorrhœas are purulent and mucopurulent, and these occasionally tinged with blood. As these discharges are always a sign of inflammatory action somewhere in the ear, whenever they occur, we have an otitis either acute or chronic, and these may be located either in the external ear, giving us an otitis externa, acute or chronic, or in the middle ear, giving us an otitis media, acute or chronic. There are a few complications of these different forms of otitis which so frequently occur that they have almost attained the dignity of separate diseases in our nomenclature. Among these the secretion of pus is the most common perhaps, and this gives us purulent otitis externa, acute or chronic, and purulent otitis media, acute or chronic. With the chronic form of purulent inflammations polypi are often developed and the presence of these should be indicated in a careful diagnosis, and so we have as a common name chronic purulent otitis externa, or media, with polypi.

Some go so far as to mention the fact of a perforation of the tympanic membrane with chronic purulent inflammations of the middle ear, and give us chronic purulent otitis media, with per-

* Read before the Buffalo Medical Club, Sept. 14th, by Dr. F. W. Abbott, and requested for publication by the Medical Journal Association.

foration, but perhaps this is an extra refinement, for if there is a formation of pus in the middle ear, it must, if it appears externally, come through a perforation in the drum membrane. Inflammations of the external ear may be either circumscribed or diffuse, giving us acute circumscribed otitis externa, acute diffuse otitis externa, chronic circumscribed otitis externa and chronic diffuse otitis externa. Any of these forms may produce a true otorrhœa, although it is temporary in the acute cases.

From this long list of different diseases, which are all accompanied by an aural discharge, we see at once the necessity of a careful inspection of each case, to learn the exact source of the discharge, before attempting to treat it.

In considering these affections in detail, we will commence with the external meatus and proceed inward. The most common otorrhœas having their origin in the external meatus should be traumatic, being produced by the surgeon's knife. Circumscribed inflammations, alias boils, are very frequent in this locality, and the proper treatment for these is an early and free incision. If the boil is near the concha, reflected light is not absolutely necessary, but if it is some ways within, direct illumination is unsatisfactory. When you see the point you want to cut, introduce a narrow-bladed knife, with its back to the wall of the meatus, and pierce the swelling and cut towards the centre. Of course, your patient will jump, but let him; you must pierce as deep as you want to go before he has time to jump, and as he gets away from you the knife cuts its way out of the apex of the boil. If you cut down on to it, your knife is apt to keep on in the same direction after it leaves the meatus, and you gash the tragus or anti-tragus, and your patient objects to a slashed ear. If you produce a satisfactory otorrhœa by this means, cleanliness by means of warm water and a syringe completes the cure. A free and early incision is considered to be a good prophylactic against the recurrence of these boils, which is often one of the most troublesome features of these cases. Should they recur, however, sulphide of calcium in one-tenth grain doses, every four hours, is the thing to give. I prescribe it frequently and am satisfied empirically that it does have an effect in preventing recurrent boils.

There is a form of genuine otorrhœa dependent upon diffuse inflammation of the external meatus, which is sometimes quite profuse, and if its true source is not recognized and correctly treated, may run on for years. This inflammation is eczematous in character, and fostered by the warmth and moisture of its habits, and encouraged by various wet applications, and especially by the application of glycerine, which to some minds appears to be a specific for all kinds of ear trouble, it runs on and the ear itches and burns until life becomes a torment. The first thing to do with such an ear is to cleanse it thoroughly with warm water and syringe, and dry it with absorbent cotton. The whole meatus, from anti-tragus to membrane, is red and swollen with ridges, fissures and excoriations. The first direction to give is, that it must be kept perfectly dry. The surgeon must cleanse it with water, if necessary, and dry it as soon as possible, but the patient must not wet it at all. In my practice the best results have followed the use of a .10 or .15 solution of nitrate of silver, thoroughly applied after the skin is dry and clean, using a saturated wisp of absorbent cotton on a cotton holder. After a few minutes I dry it carefully again, and follow this up every day, if it gets moist in one day. Very soon the discharge decreases, so that no moisture appears, but the discharge dries in flakes as fast as secreted. Then, after applying the nitrate of silver, I sometimes apply a thin coating of yellow oxide of mercury ointment, made with cosmoline. Occasionally a polypus is found hanging to the wall of the external meatus with a perfect drum membrane, although they are rare; so I will say what I have to say of the treatment of polypi here. A profuse otorrhœa often comes from a little polypus, which may be nothing apparently but a small granulating surface; so this is one of the first things to look for in a running ear. When found, it isn't always necessary to scare your patient to death by telling him he has a polypus. If he is nervous and imaginative, he will picture a many-rooted monster sending claws deep into his brain, or ask anxiously if it is a cancer. But at all events get rid of your polypus. If it is pediculated, pick it off with forceps or snare and touch its point of attachment with chromic acid. If it has a broad base, cover it with

chromic acid and repeat the application from time to time. It may be necessary to scrape the exuberant granulation with a curette. If there is denuded carious bone, it is necessary to scrape this well until you reach sound tissue.

But by far the most abundant source of the discharge in otorrhœas is the mucous membrane lining the cavity of the middle ear. An acute inflammation of the pharyngeal mucous membrane, especially such as accompanies scarlatina, and after this a long-ways measles or an idiopathic pharyngitis extends by contiguity of tissue through the Eustachian tube to the middle ear. Mucus is secreted and fills the cavity, the inflammation grows more severe, pus is formed, and, having no means of exit, finally breaks through the drum membrane and shows itself externally. But this bony cavity cannot empty itself completely through this orifice. Some pus stays, perhaps decomposes and becomes a source of irritation. More is secreted, which goes through the same processes, and finally we have lining the middle ear a pyogenic membrane, and a continuous discharge. Complications soon ensue; the continued moisture and warmth encourage the growth of granulations, and polypi spring up. Perhaps the inflammation spreads to the mastoid cells, and here we have as a result ulceration, necrosis, finally an opening externally and relief from pain and fever with a sinus connecting the surface of the mastoid bone with the middle ear. Perhaps the ulceration and necrosis extend inward, reach the meninges of the brain, setting up meningitis, acute, spreading, with death, or chronic meningitis with all its attendants, epilepsy, mania, dementia, etc. Perhaps ulceration begins in the middle ear; its cover is a thin lamella of bone, which separates it from the dura mater here. Necrosis often, sooner or later, destroys this lamella, and the dura mater becoming implicated, we have the same results of meningitis as mentioned before.

So a running ear is not simply a source of annoyance, as it is often considered, still less a sort of drainage tube, letting off foul humors, deleterious to the system, which must not be interfered with, as is still the belief in some quarters; but it is a sword of Damocles hanging continually over the head of its possessor and threatening life itself.

Since the results of a chronic purulent otitis media are or may be so appalling, the question of the proper treatment becomes a very urgent and important one, and it will not do for any physician into whose hands a family have entrusted themselves in good faith, relying upon his knowledge of disease, to say, as I have too often heard, "Well, I don't know anything about ear diseases, and I don't want to." This disease is usually very easily diagnosticated, and the rationale of the treatment is very simple: cleanse the ear thoroughly with syringe and absorbent cotton, and inspect it through a speculum with reflected light. A speculum may be bought for fifty cents, and in these days every physician should have a laryngoscopic mirror; but if you haven't, take a bit of looking glass and scrape a little hole through the silver. With this simple reflector you can light up the meatus so that you can tell whether its walls look healthy or not, and, if they do, you can reason, by exclusion, that the middle ear is affected, even though you do not get a satisfactory view of the drum membrane.

Usually a hole in the ear drum can be seen and distinguished, but often it cannot. It may be in the lower anterior segment, out of sight, around the bend in the external meatus; or the drum membrane may be inflamed and discolored so that you are not sure whether it is drum membrane which you see or the internal wall covered with mucous membrane. Sometimes you can diagnosticate a perforation by listening closely while the patient inflates the Eustachian tube and middle ear by the Valsalvian method. If a perforation exists and the Eustachian tube is pervious, you will hear the whistle of the air as it passes through. I have read somewhere of putting a light bit of cotton in the ear in such cases and expecting to see it blown out, but this experiment has never succeeded under my observation. If you cannot hear the whistle of air, and are still in doubt, drop a little warm water into the ear and watch it through the speculum while the patient inflates the ear, and you may be rewarded by seeing bubbles of air break through the water. Of course, if you have a Politzer bag you won't linger over the Valsalvian method, and one pull through a Siemen's speculum settles the case; but I am not supposing that you have an otologist's armament.

Having established your diagnosis, the treatment comes next. You want to restore that mucous membrane to its normal condition, where it is possible, and induce a cicatrization of ulcerated surfaces. The first need is cleanliness, and cleanliness without violence. For this you will need more tools. A mirror on a head band, which leaves both hands free, is absolutely essential; no one has any business with a purulent otitis media without one. After syringing the ear long and carefully, dry it out with absorbent cotton, under your eye. You must always look and see where you are going; the structure of the ear is too delicate for blind poking. Patients and friends cannot cleanse an ear; you must do it yourself, or it won't be done. I know one man who, after 15 or 20 years' practice, can cleanse his own ear. He puts a piece of slender flexible rubber tubing on the nozzle of his syringe and inserts that into his ear; as he has no ear drum, the way is clear to the bottom of the hole. After pumping from a pint to a quart of water through this, he dries his ear with absorbent cotton on a cotton holder, and this he can insert clear into the middle ear. As he does this every day, no pus collects and hardens. This is the single exception that proves the rule that no man can cleanse his own ear. After the ear is clean, the question of what application to make comes up, and here a pretty wide choice presents itself, and the very variety of the remedies which have been mentioned only proves that no one has been found entirely satisfactory. I more frequently begin with blowing in finely-powdered alum than in any other way, and repeat this every other day. I often, when this fails or seems to have too little effect upon the inflamed membrane, use finely-powdered iodoform or iodoform and alum. The great objection to iodoform is its odor, and this becomes very disagreeable in using iodoform in this manner. When one puffs a cloud of iodoform into a patient's ear, the return blast loads his moustache with the powder and he carries it under his nose the rest of the day. Some medical journals, a few months ago, vaunted boracic acid as the application in purulent otitis media, but in my hands it has not proved a specific by any means, but a useful variation. These powders act better when the drum membrane is almost entirely destroyed, I think,

and a puff applies them thoroughly to every part. When the perforation is small and in the upper part of the membrane, the case presents peculiar difficulties. It is very difficult to cleanse such an ear, and here especially, after syringing thoroughly, it is beneficial to blow through the Eustachian tube by Valsalva's method, or the air bag, to force the middle ear fluids through the perforation in the external meatus, where they can be wiped out with cotton. In such cases I have had the best results from the use of strong solution of nitrate of silver .10 to .15. After cleansing the ear by all ways as thoroughly as possible, I have the patient lie on the side, with the affected ear uppermost. Then with a pipette introduced well into the ear, I drop in 10 to 15 drops. I then pull and work the ear so as to churn it down clear into the middle ear, and be sure that it reaches every part. After leaving it a few minutes, I draw out what I can with the pipette, and put in a little pure warm water, then pump this out and put in some more; finally I drop in a solution of salt to decompose the nitrate of silver that may be left. The principal object of this procedure is cosmetic. Should the patient arise with an ear full of a .15 solution of nitrate of silver, a long, dirty-brown streak from ear to shirt collar would confront you at the next visit. Sometimes you have the good fortune to see a perforation close up, which is a consummation most devoutly to be wished, as this protects the mucous membrane of the middle ear from external irritants. If the drum membrane does not close up and the secretion stops, it is best to wear a loose pledget of cotton for a protection.

Dr. Howe spoke very highly of permanganate of potash in solution, for purulent otitis media, in a paper published some time ago. He gave it to the patients for ear drops. I used it some, but the patients objected to the stains left by this salt on everything it touched, and in my hands it did not prove as efficacious as I had hoped it might, from the statistics given in its favor.

Where patients cannot come to the physician for treatment, they should provide themselves with a good ear syringe and keep the ear as clean as possible. If all the pus and mucus is not removed, it can be kept fluid and wholesome, so that none will be blocked in behind dry, hardened masses, and the penetrating odor, which makes

so many running ears an offense to the whole household, will be prevented. Should mastoid-cell complications arise, an incision should be made into the mastoid at once, with a strong knife or trephine.

There is much more that might be said about otorrhœa, but I have occupied my half hour, and I don't think I ought to read any more to-night.

BUFFALO, Sept. 17th, 1881.

Gentlemen:—My incomplete paper on otorrhœa, which you have kindly expressed a desire to publish, was supplemented, in some particulars, in the discussion upon it which followed its reading. Thinking that these questions might arise in the minds of some of your readers, I have taken the liberty of appending a few of them with their answers, as well as I can remember them.

Dr. D. The doses of sulphide of calcium as given in the paper (1-10 grain) are entirely inert. Experiments have shown that 1-grain doses are required to produce any effect, and 5-grain doses may be given without ill effects.

Answer by Essayist. I have never failed in stopping recurrent boils in the ear by the use of 1-10-grain doses of this drug. When I do, I shall recommend the smaller ones until they fail.

Quest. Is sulphide of calcium useful in boils occurring elsewhere than in the ear?

Dr. M. I was cured by it last spring, of recurrent abscesses in different parts of the body.

Dr. G. I am disappointed that nothing was said in the paper about the treatment of the acute stages of otitis media, which occurs specially in the course of exanthemata. Will you say something on this point?

Ans. This subject did not come strictly within the range of my subject, but I will say, in all cases of acute otitis media I use first hot water, directing the patient to hold his head over a bowl, and continually instilling into the ear water as hot as can be borne, keeping the supply hot by adding boiling water. This to be continued ten to fifteen minutes or until the pain ceases. Repeat this every hour or two, using in the meantime ear drops of Magendie's solution of morphine. If the pain is not entirely relieved by this, apply some leeches to anti-tragus and tragus, putting some cotton into the ear to prevent them going in and fastening on to the drum membrane.

Dr. H. Is there any means of telling whether there is a collection of fluid in the drum cavity in these cases, and if so, what is the remedy?

Ans. Yes; upon inspection the drum membrane appears to bulge outward, and it has lost its translucent look. Then an incision should be made through its lower posterior part.

Quest. Is there any danger that this incision will not heal up?

Ans. No. It is extremely difficult to maintain a traumatic perforation of the drum membrane in cases where it is desirable.

Dr. M. Is not such an application of nitrate of silver as you describe very painful?

Ans. It is not. It causes no pain, if the cuticle lining the external meatus is intact.

Quest. Is not the chromic-acid application painful?

Ans. It is not, if the application is made only upon the polypus, and the acid is not allowed to touch any healthy tissue. I twist a little point of cotton on my cotton holder and dip just the tip into some chromic acid, which has deliquesced and become fluid without the addition of any solvent; with this I touch just where I want to. If it should run on to sound tissue and cause pain, this can be relieved by gently syringing with warm water.

Yours truly,

F. W. ABBOTT, M.D.,

Buffalo Medical and Surgical Journal, Oct., 1881.

BOOKS AND PAMPHLETS RECEIVED.

—"A Treatise on Hygiene and Public Health." By various authors. Edited by Albert H. Buck, M.D. 2 vols. Illustrated. New York: Wm. Wood & Co.

—"A Treatise on Food and Dietetics, Physiologically and Therapeutically Considered." By F. W. Pavy, M.D., F.R.S., Fellow of the Royal College of Physicians, etc. Second Edition. New York: Wm. Wood & Co., 1881.

—"A Manual of Histology." Edited and prepared by Thomas E. Satterthwaite, M.D., of New York, President of the New York Pathological Society, etc., etc. New York: Wm. Wood & Co., 1881.

—"The Black Arts in Medicine, with Anniversary Address." By John D. Jackson, A.M., M.D. Edited by L. S. McMurry, A.M., M.D. Cincinnati; Robert Clarke & Co., 1880.

—"A Practical Manual of the Diseases of Children, with a Formulary." By Edward Ellis, M.D. Fourth Edition, revised and enlarged. Philadelphia: Presley Blakiston, 1881. Price \$3.50.

—"A Manual of Ophthalmic Practice." By Henry S. Schell, M.D., Surgeon to Wills Eye Hospital, and Ophthalmic and Aural Surgeon to the Children's Hospital. Philadelphia: D. G. Brinton, 1881.

The American Specialist.

COMMUNICATIONS for the Editorial Department of this Journal, Books for Review, etc., should be addressed to the Editor, care of the Publisher.

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PRESLEY BLAKISTON,

1012 Walnut Street, Philadelphia

PHILADELPHIA, JANUARY 1, 1882.

AU REVOIR.

My first editorial I entitled *Salutem*; this, my last, I will call "*Au Revoir*." With this number my editorial connection with the AMERICAN SPECIALIST ceases. I desire to return my sincere thanks to all the friends of the journal and to medical publishers, for kindnesses received. I trust, since I have had no reason to think otherwise, that my wish (expressed in "*Salutem*"), "*That when his time shall come, he may retire from the editorial chair without the ill will of even the most insignificant of them*" (Editors), has been fulfilled. I now, therefore, say to my literary friends, *Au Revoir*; I bid you good-bye in the SPECIALIST.

Correspondence.

CORRECTION.

1611 Chestnut St., December 5th, 1881.
To the Editor of the American Specialist:—

DEAR SIR: I observe in the December number of the AMERICAN SPECIALIST a reference to my having received a cablegram from the editor of the London *Lancet* requesting me to furnish an article on the case of the late President Garfield, and for which I had to pay several dollars. It is proper that a correction should be made, and I hope you will do me the favor, and the editor of the *Lancet* the justice, to make the correction in the SPECIALIST.

IST. It is true the request to prepare such an article was made, and that the cablegram cost between two and three dollars, but on inquiry I have learned that this cost was due to sending copies to different places in order to reach me, and not for the original cablegram, which was prepaid.

Yours truly,

D. HAYES AGNEW.

Editor Specialist:—

DEAR SIR: As you invite news items in specialties, I send you one which I hope may induce others to profit by it. The following will be found as near specific as medicines may ever hope to become, for "pannus" and all forms of subacute and chronic injections of the conjunctival vessels:—

R. Fld. ext. ergot (Squibbs).

SIG.—One large drop in the eye, at bedtime: full strength.

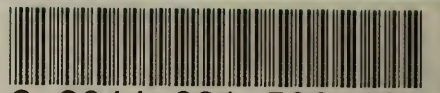
DR. H. S. HUMPHREY.

Janesville, Miss., Nov. 20th, 1881.

Miscellany.

—A few days ago Dr. J. M. Green, of the Marine Hospital Service, stationed at Key West, died, of yellow fever. He leaves a family unprovided for. If Congress were in session it is likely some action would be taken on this instance, looking toward a permanent provision of pensions for the widows and orphans of medical officers dying at their post. According to the regulations of the service, the class of officers to which Dr. Green belongs are the first to be exposed to contagious diseases from foreign ports. It is a singular oversight that our Government has not already provided aid for those made destitute by the performance of an official duty which entails such exposure. France has led us in this matter, although we trust our next Congress will follow her example.—*Louisville Med. News*, Oct. 15th, 1881.

AN IMPROVED CATHETER.—This story (case of relief by a wire) reminds us of an occurrence of similar nature on one of our river boats. An elderly woman, second-class passenger, was found during the night to be groaning and suffering much pain. The watchman, after searching the list of passengers, waked up Dr. W., who happened to be on board. He found a greatly distended bladder to be the cause of the trouble. He had no catheter; finally it occurred to him that his toothpick might be pressed into the service. He borrowed a second quill from a friend, and having fastened the two together, passed this novel catheter into the bladder and received the blessings of the sufferer.—*Canada Journal*, September, 1881. *Cin. Lan. and Clin.*, Oct. 8th, 1881.



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